

## Carolina ACCESS Override Request

Complete this form to request a Carolina ACCESS override when you have received a denial for EOB 270 or 286 **or** the Primary Care Provider (PCP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted within six months of the date of service. Overrides will not be considered unless the PCP has been **contacted and refused** to authorize treatment. Attach any supporting documentation. Mail or fax completed form to EDS. EDS will telephone or fax your office within 30 days with a denial or, if approved, the override number to use for filing the claim. This form is also available in the Carolina ACCESS Primary Care Provider Manual and on DMA's website at <http://www.dhhs.state.nc.us/dma>.

**Mail To:** CA Override  
EDS Provider Services  
PO Box 300009  
Raleigh, NC 27622

**OR**

**Fax:** CA Override  
919/851-4014

Recipient MID No. \_\_\_\_\_ Recipient Name \_\_\_\_\_

Date(s) of Service \_\_\_\_\_ ICN No. \_\_\_\_\_ RA Date \_\_\_\_\_

Is this claim due to?

- ☐ A well visit  
☐ An inpatient admission  
☐ An inpatient admission via the ER

PCP on recipient's Medicaid card \_\_\_\_\_

Name of person contacted at PCP's office \_\_\_\_\_ Date contacted \_\_\_\_\_

Reason PCP stated he would not authorize treatment \_\_\_\_\_  
\_\_\_\_\_

Reason recipient stated he did not go to the PCP listed on his Medicaid card \_\_\_\_\_  
\_\_\_\_\_

I am requesting an override due to:

- ☐ Enrollee linked incorrectly to PCP. Please explain: \_\_\_\_\_  
\_\_\_\_\_  
Who is the correct PCP? \_\_\_\_\_
- ☐ This child has been placed in foster care in another area: \_\_\_\_\_
- ☐ This enrollee has moved to another county: \_\_\_\_\_
- ☐ The provider listed on the enrollee's Medicaid card is different from the PCP indicated by the AVR system (attach a copy of the Medicaid card with this form).
- ☐ Unable to contact PCP. Please explain: \_\_\_\_\_  
\_\_\_\_\_
- ☐ Other. Please explain: \_\_\_\_\_  
\_\_\_\_\_

Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_

Provider Contact \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_ Fax No. (\_\_\_\_) \_\_\_\_\_